DOCUMENT RESUME

ED 257 284 EC 172 712

AUTHOR Hite, Mark C.; And Others
TITLE Family Constellations of Mentally Retarded Individuals: The Changing Role of the School Psychologist.
PUB DATE Apr 85
NOTE 18p.; Paper presented at the Annual Convention of the Council for Exceptional Children (63rd, Anaheim, CA, April 15-19, 1985).
PUB TYPE Speeches/Conference Papers (150) -- Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Counseling Techniques; Elementary Secondary Education; Family School Relationship; *Intervention; *Mental Retardation; *School Psychologists; *Staff Role

ABSTRACT

The paper identifies some of the needs of parents of retarded children and proposes that school psychologists can promote more effective parent-school relationships. Two case studies illustrate family concerns with moderately retarded adolescents and describe interventions to provide immediate, short term solutions. The central function of the special education school psychologists is described, and six major role changes are seen to include consultation for home and school behavior, inservice training for teachers on basic family dynamics, group counseling and education on stress management, counseling of individual families as a crisis intervention, and referral to the network of other mental health professionals. (CL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED257284

Family

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

Family Constellations of Mentally Retarded Individuals: The Changing Role of the School Psychologist

Mark C. Hite and David J. Kleber

Oakridge School

Provo, Utah

Katherine E. Simpkins

Department of Educational Psychology

Brigham Young University

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Mark C. Hite

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

EC177212

Paper presented at the Annual Convention
of the
Council for Exceptional Children
(63rd, Anaheim, CA, April 15-19, 1985)

Family Constellations of Mentally Retarded Individuals: The Changing Role of the School Psychologist

Historically, focus on the needs of families of mentally handicapped individuals has been on providing education as a form of counseling rather than therapy. These services were, generally speaking, to educate families about their handicapped child in hopes of remediating unnecessary stress through information. Curriculum for these counseling classes ranged from teaching the causes and effects of retardation to exploring the educational opportunities of the day that were open to the child (Popp, Ingram, and Jordan, 1954). At that time counseling topics such as etiology, developmental delays, and emotional needs were seen as important information for families. Even more recently attempts were still made to increase self-perceptions of parents towards their handicapped child through a specific curriculum model which provided information as a means of counseling (Mahoney, 1980).

By the early 1960's experts on mental retardation began to develop family counseling plans that suggested greater emphasis be put on the family as a whole. Kanner (1961) suggested that counselors provide for the emotional needs of the family through focusing on the family structure as it related to the retarded child. Jordan (1976) developed specific guidelines for the counseling professional to address the needs of parents.

More recently there has been a shift (although not a dramatic one) towards the therapeutic needs of families with handicapped children. However, this shift has been directed to the general handicapped population, with little emphasis on families of the mentally retarded.

Gregg (1968), using a professional team consisting of a pediatrician,

BEST COPY AVAILABLE

a psychologist, and a social worker that functioned similar to today's IEP team, sought to reduce anxiety and emotional disturbance in families by educating them about the maximum achievement potential of the child. Kaslow and Cooper (1978) suggested that teaching parents coping skills and helping them better understand their child would remediate stress in families of the learning disabled. Estreicher (1982) utilized a play therapy technique to assist parents of retarded children to increase positive attitudes towards their child. Parker (1980) and Kolb (1981) each developed structured group programs to assist parents in accepting their handicapped child more readily. In both cases parents reported greater satisfaction with their handicapped child as a result of this counseling.

When considering these and other programs that have been developed to assist families of handicapped children, and more specifically, families of mentally retarded children, it is clear that there is a need for a more developed research plan of attack by the professional world. Programs with therapeutic and educational bases need to be worked out to effectively provide the needed services so long unavailable to this population.

In IEP meetings attended by the authors, family dysfunction often was manifested in parental negative attitudes toward their children. Often teachers and other professionals experienced difficulties when attempting to implement the IEP because of these negative attitudes. Parents focused on accepting their child and, consequently, directed their attention from their roles in the implementation of the IEP.

BEST COPY AVAILABLE

Statement of Purpose

The purpose of this presentation is to identify some of the needs of parents of retarded children and propose a possible solution for educational professionals that would begin to address the needs of parents as well as students. Suggestions will be made as to the manner in which our profession may begin to bridge the gap between itself and the psychotherapeutic profession for the benefit of families of the mentally retarded individual. To illustrate the effectiveness of this solution, two case studies recently undertaken at the Oakridge School in Provo, Utah will be examined.

Case #1

This student was an eighteen year old, moderately retarded male. He was the oldest of three children, with a thirteen year old sister and a newborn brother. He had been educated for most of his life in a self-contained classroom at a school specially designated for trainable mentally retarded children. Ha had, over the years, classes in academics, both formal and survival, and was currently reading at an early first grade level. However, comprehension skills were at a pre-first year level and decoding skills in the mid-first year range. Math skills were also classified in the mid-first year level. A strong dyadic bond existed between mother and son and often the bond was strengthened to the point of over-parentification when negative interactions occured between father and son. Over-parentification may be defined as excessive pampering and/or displays of affection toward a child by the parent(s), which includes the encouragement of a complete dependency on that parent or parents. For most of his eighteen years, or at least as long as retardation was apparent, the father had been abusive towards the subject

BEST COPY AVAILABLE

both physically and emotionally.

Insert Table 1 about here.

This had greatly affected the subject and his family. Most recently severe depression had surfaced characterized by extreme affect changes and withdrawal as its symptoms. This had severely limited the effective implementation of the IEP.

The subject's mother sought assistance from the homeroom teacher and the school psychologist for these problems following the birth of the youngest sibling. Specifically, she cited the unwillingness of the subject to get out of bed, to go to school, and his withdrawal from normal daily activities following forceful efforts by the father. Reinforcers such as favorite breakfasts, trips to fast food hamburger shops, and other activities usually effective in bringing about desired behavioral results were no longer adequate. The subject's only desire was to withdraw by staying in bed. Arguments ensued followed by violence on the part of the father. The more intense the situation became, the more willing the subject was to take his punishment and return to bed. Beatings and high intensity demands for behavior compliance, once effective as a fear factor, were met with resistence and withdrawal.

Case #2

Subject #2 was a seventeen year old male from a family of five, including father, mother, and two younger sisters. The subject was classified moderately mentally retarded as a result of undetected phenylketonuria at birth. For the first several years of education he was

BEST COPY AVAILABLE

entered in the regular public school setting with a resource curriculum. By seventh grade, deep emotional disturbance emerged, attributed primarily by his parents to the pressures of competition with and ridicule from peers. Placement in the secondary program at a specially designed school for trainables followed, and had lasted for the past four years. Academic achievement had been higher than most of his peers in this most recent setting, but emotional problems were still present.

The presenting problem involved intense emotional interaction between the subject and his thirteen year old sister (see Table 2), brought to the attention of the homeroom teacher and the school psychologist by the subject's father, who himself is a special educator. Interaction between the subject and his sister was chararacterized by badgering, arguing, and physical aggression. On the presenting occasion, the situation escalated to an extreme so sufficient that an abnormally intense reaction by the subject resulted. The subject struck his sister with a steak knife slightly breaking the skin which alarmed the entire family.

Insert Table 2 about here

Interventions For Case Studies

In both case studies several interventions were utilized to provide an immediate, short term solution. In the first case, the intervention provided immediate relief to the family while referral was made to the proper clinical professionals for long term therapeutic needs. The subject's mother attempted to call the school psychologist to inform him of the crisis at hand and ask for immediate help. Since the psychologist

BEST COPY AVAILABLE

was unavailable the mother's second option was to call the homeroom teacher, who was already informed about how the system worked. Mother described the situation as volitile and dangerous to the subject. The first intervention was to make a home visit and attempt to remove the subject from the crisis by bringing him to school, capitalizing on the fact that the school was the only significant support system that could be trusted. At school, time was given to the subject to sort out his feelings and communicate his desires and fears. He was told that he must be at school; however, pressure to perform was removed. Direct support was given to the subject by mobilizing the efforts of the entire staff. This was done to provide the trusted support system the subject was requiring at this time. The third intervention was for the benefit of the entire family. The parents were invited to school for a counseling session. The session was successful in breaking up the interactional pattern which relieved the subject from the immediate threat, while establishing a more appropriate interactional pattern for future conflicts. However, deep seated feelings of guilt and frustration surfaced in both parents, suggesting a need for referral for long term family therapy.

In case two the crisis intervention, coupled with follow up phone contacts, was all that was needed. Understanding the system through previous use, the subject's father contacted the psychologist in a specific plea for help. The initial intervention assisted the parents in understanding that this incident was not unraveling all their previous training in behavioral control. Perceptions and fears by the parents that one volitile situation in the family did not result in everything lost were dispelled. Secondly, the father was directed to intervene into the sister-brother dyad to break up that interactional pattern. This was

BEST COPY AVAILABLE

accomplished by removing the sister from the area where the conflict occurred. Thirdly, father was instructed to remove the subject from the crisis setting by allowing a cooling off period followed by the creation of an atmosphere of support, love, and concern rather than confronting him with more conflict. This allowed for an uncovering of the subject's feelings while establishing a counseling dialogue between father and son. This was much more effective in maintaining long term stability than if the psychologist had directly intervened. Finally, the family was offered a therapy session at school as a debriefing to give some immediate solutions to resolve the crisis and was offered the option of long term therapy. However, the crisis intervention proved effective and long term therapy was not necessary at this time. The family now has many options at their disposal should it be needed in the future.

Recommendations

Typically, when families and/or couples experience stressful situations, places are available for them to relieve symptoms. Family clinics, psychologists, literature, and often a network of support systems such as friends, family, and church are available. However, for the family of the mentally retarded child, resources for crisis intervention are often not available of families are unaware of their existence. Often the support systems normally available are relatively useless to the family of the mentally retarded because of the uniqueness of the source of much of the stress and depression. When stress is overburdensome conflict arises. These common support systems, including the professional world, do not possess the necessary understanding of the problems surrounding the mentally retarded child to deal effectively with the situation.

BEST COPY AVAILABLE

Where do parents receive the crisis intervention they require when coping becomes too burdensome? With reference to the two case studies, what intervention was provided to assist families in crisis, while at the same time creating a conducive life environment for which the mentally retarded child was able to continue meeting individual education goals? The school psychologist was a logical choice. However, changes in thinking as to how the school psychologist may be utilized in this capacity are necessary on the part of school districts.

During times of crisis there are several significantly influencing systems within the mentally retarded child's life that may help. We have mentioned parents, but crisis intervention is needed for all members of the immediate family. School is the one significant system of the child that is in a position to effectively assist. If the role of the school psychologist in special education were to change, what might his/her role look like?

We have identified six major role changes for the special education school psychologist that address these issues. First, the psychologist becomes a consultant to teachers as students show an increased behavior problem due to family crisis, which renders implementation of the IEP most difficult. This would give the teacher an immediate support in dealing with the new, undesired behavior. Special staffing, provided by the IEP process under the law, would provide a vehicle in which school staff might develop strategies for remediating behavior at school. This is not unlike the role already being provided by many psychologists. However, under this proposed plan the psychologist would think beyond the school setting and consider possible variables in the home affecting the child's behavior. Hypotheses might be formulated and discussed by all

BEST COPY AVAILABLE

staff members and decisions made as to course of action taken towards remediation. In this vein, the psychologist may become a liason between parents and teachers as he/she troubleshoots the situation by contacting the home.

Secondly, the psychologist might conduct inservice training for teachers as to basic individual psychological principles and principles of family dynamics. With this new information about mental health and signs of deviation, teachers would alert the psychologist when signs became apparent through IEP or other parent-teacher meetings. Role number 1, mentioned in the previous paragraph would follow this identification of potential problems.

A third role, used as a preventative measure, would be group counseling and education concerning stress reduction and management. Two or three workshops teaching parents techniques for coping with the pressures of raising a handicapped child as well as utilizing group dynamics to provide families with an additional support system might help prevent many of the more advanced family conflicts before they develop. Other group counseling sessions could be held as the need arises throughout the life of the child. For instance, such groups might provide counseling for parents with children entering school or for parents whose children were entering puberty.

Counseling of individual family units as a crisis intervention is the fourth role of the school psychologist. Often, families in crisis who have an intellectually impaired child, have no place to receive the immediate attention when a problem arises. If the psychologist were recognized as an available resource for crisis intervention, families might utilize him/her to receive an immediate strategy for relieving the stress. Cases

BEST COPY AVAILABLE

number one and two were examples of families where the school psychologist was used as a mental health resource. It must be noted here that we are not suggesting that the psychologist be offering long-term psychotherapy. Rather, this recommendation suggests that the school psychologist provide the needed crisis intervention that pertains to an immediate problem facing a retarded individual and his/her family. Secondly, the psychologist would refer if needed, the family to other psychotherapist professionals for long-term therapy.

Individual counseling of parents to dispel myths concerning retarded children is the fifth role. This would apply to families of newborns, toddlers and pre-schoolers, primarily. However, other occasions such as puberty might be likely individual counseling opportunities. Subjects such as genetic counseling, behavioral traits, current research on education and child prognosis may be pertinent under this role.

Finally, the special education school psychologist must establish a network of other mental health professionals with which referrals might be made to address the complex issue not readily handled by him/her. This network would include family therapists, clinical psychologists, social workers, psychiatrists, and area vocational rehabilitation agencies. He/she would also want to establish connections with the local legal centers for the handicapped to address issues of legal matters. Where possible, he/she may want to hold workshops for these professionals to familiarize them as to the characteristics of mentally retarded individuals and their families. These professionals should be available to provide the needed assistance following the crisis intervention by the school psychologist.

With these changes within the role of the special education school

BEST COPY AVAILABLE

psychologist, teachers would be free to teach students who were operating in a home and school environment more conducive to learning. The psychologist would become much more valuable to the school setting than merely one who assesses and evaluates. By expanding his/her work role to full-time within the special education setting, time would be available for both jobs to be completed.

In the case first presented, family crisis intervention was successfully provided and the student quickly was able to turn his efforts back to school issues while interactional patterns were modified for the benefit of all concerned. However, it was anticipated that referrals were needed for long-term therapy for the parents in light of the fact that interactional patterns of a negative nature had been long-established. The father wanted to change but needed more in-depth therapy to facilitate the change. The system was in place for him to receive it. Likewise, the student might be in need of some extended psychiatric assistance for the depression he had been experiencing. However, the system did intervene and stopped a crisis before a tragedy occurred.

In the second case, most of the presenting problem was eliminated following one session that focused on brother-sister interaction and family strategies for relieving the pressure, although case number two was still somewhat of a behavioral "powder keg", sister now had techniques at her disposal for not lighting it. Both families reported that having the system to work with them had stopped the crisis before it got out of hand. Since they had somewhere to take their problems, more severe family disruptions were averted.

BEST COPY AVAILABLE

Table 1

Summary Data for Case 1

Client: Male

Age: 18

Educational Classification: Severe Multiple Handicap Mental Retardation (Communication Language)

Retardation Level: Moderate

Education: Primarily Self-Contained Functional-Survival

Family: Mother, Father, Sister (13), Brother (Newborn)

Presenting Problem: Severe depression (caused by?) a withdrawal reaction to extremely poor father-son relationship.

Interactional Cycle of Behaviors:

Upsetting Situation --> Subject Withdraws --> Parents Worry-Insist -->

Subject Rejects Insistence By Further Withdrawal --> Parents Escalate -->

Subject Further Resists ---> 1. Parents Ignore --->
2. Buy Off ---> Subject --->
3. Physical Enforcement --->

Remains in Bed.

Intervention: Crisis Oriented; Referral for Long Term Family Therapy.

BEST COPY AVAILABLE

Table 2

Summary Data for Case 2

Client: Male

Age: 19

Educational Classification: Severe Multiple Handicap (Mental Retardation and Emotional Disorder).

Retardation Level: Moderate

Education: Integration into Public Mainstream with Resource Self-Contained (Past 5 Years).

Family: Mother, Father, 2 Sisters

Presenting Problem: Escalating Emotional Disturbance (Caused By?) Sibling Rivalry with 13 Year Old Sister.

Interactional Cycle of Behaviors:

Sister Nags --> Subject Becomes Annoyed --> Sister Continues to Criticize --> Subject More Annoyed --> Subject Lashes Out With Knife --> Sister Surprised, Runs Off --> Parent Enters Scene - Horrified -->Confronts Subject --> Subject Becomes Scared and Defensive --> Father Escalates Demand for Control --> Subject "Loses It" and blows Out All His Emotions That Have Been Building --> Finally With Emotion Spent --> Subject Goes to Room --> Father Still More and More Frightened --> Calls School for Assistance.

Intervention: Crisis Oriented; Follow-Up Phone Visits; Individual Counseling at School for Subject.

BEST COPY AVAILABLE

References

Estreicher, D.G. (1982). "The development of family therapy techniques for families with developmentally delayed children". Page 3384 in volume 43./10-B of Dissertation Abstracts International.

Cregg, G.S. (1980). "Comprehensive professional help for the retarded child and his family". Hospital and Community Psychiatry. 19(4), 122-124.

Jordan, T.E, (1976). The Mentally Retarded. Columbus, Ohio: Charles Merrill Publishing Co.

Kanner, L. (1961). "Parents feelings about retarded children". American Journal of Mental Deficiency. 57, 375-383.

Kaslow, F.W. & Cooper, B. (1978). "Family therapy with the learning disabled child and his/her family". Journal of Marriage and Family Counseling. Jan. Vo. 4(1), 41-49.

Kolb, C.E. (1981). "The effectiveness of a structured group experience on a mother's adjustment to a handicapped child". Page 2063 in volume 42/05B of Dissertation Abstracts International.

Manoney, J. (1981). Parent education for families with handicapped infants: A curriculum model. Unpublished doctoral dissertation, Brigham Young University.

Parker, S. (1980). "Parents with mentally retarded Down's Syndrome

BEST COPY AVAILABLE

children: Their experiences with the child and the impact of a short-term educationally oriented group on their adjustment". Page 3912 in volume 41/10B of Dissertation Abstracts International.

Popp, C.E., Ingram, V., & Jordan, P.H. (1954). "Helping parents understand their mentally handicapped children". American Journal of Mental Deficiency. 58, 530-534.

BEST COPY AVAILABLE